

## COUNTY MEDICAL SERVICES PROGRAM (CMSP) QUARTERLY STATUS REPORT

This status report is for the months of:

Month 1	Month 2	Month 3
---------	---------	---------

and should be completed after Month 3 has ended.

**IMPORTANT:** Please complete, sign, and return this form to the Welfare Department in the enclosed, stamped envelope by the \_\_\_\_\_ of \_\_\_\_\_. If you do not return this form, your eligibility for CMSP may be discontinued.

If you no longer want CMSP, please complete and sign Part A. (Do not complete Part B.) Mail this form to the Welfare Department.

### PART A. DISCONTINUANCE REQUEST

I no longer want CMSP services and would like my CMSP case discontinued as of the last day of \_\_\_\_\_ Month \_\_\_\_\_ Year

I understand that I may reapply for CMSP at any time in the future.

Signature	Date
-----------	------

**If you wish to have your CMSP eligibility continued**, please complete and sign Part B. This report does not change your responsibility to report any change to your eligibility worker **within 10 days of the change**. If you have any questions regarding this form or the items to be reported, contact your eligibility worker.

### PART B. ELIGIBILITY STATUS INFORMATION

1. I/We received income, money, or benefits during:

Month 1	Month 2	Month 3
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If "Yes," list all income and who received it. Income includes **EARNINGS** (salary, wages, tips, commissions, and bonuses); **VACATION PAY, UNEMPLOYMENT INSURANCE/DISABILITY INSURANCE**, worker's compensation, strike benefits, training incentive (CETA); **SOCIAL SECURITY/RAILROAD RETIREMENT**, supplemental security income (SSI), pensions, business, farm, rental; **CHILD SUPPORT**, contributions (step-father, others), free housing/utilities/food/clothing; **MILITARY BENEFITS**, settlements, loans and grants, gifts, and any other money you receive. **LIST GROSS INCOME (BEFORE DEDUCTIONS)**.

If "No" for all three months, how are you meeting your needs? \_\_\_\_\_ (Go to No. 4.)

ALL PERSONS IN THE FAMILY WHO RECEIVE INCOME MUST BE LISTED.

ATTACH A COPY OF YOUR PAY STUBS SO THAT YOU ARE ALLOWED ALL APPROPRIATE WORK DEDUCTIONS.

Who Received Income, Money, or Benefits	Type of Income, Money, or Benefits (see list above)	Month 1 Gross Amount	Month 2 Gross Amount	Month 3 Gross Amount	Dates Received

If additional space is needed, attach a separate sheet.

**NOTE:** Whenever you receive income of any kind, you **must** provide verification (proof of income). If you do not **submit** verification at the time you report income, or if your report is incomplete in any way, you will be scheduled for discontinuance. However, you can avoid being discontinued if you submit the necessary information/verification prior to the effective date of the discontinuance.

Check one:      ☐ Income verification enclosed.      **OR**      ☐ I will send income verification in two weeks.

**BE SURE TO COMPLETE THE OTHER SIDE OF THIS FORM.**

2. My earnings (and/or those of any family member) change from month to month. ☐ Yes ☐ No

If "Yes," how much do you (and/or family member) expect to earn (before deductions) next month? \$ \_\_\_\_\_

Month 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	Month 2 <input type="checkbox"/> Yes <input type="checkbox"/> No	Month 3 <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---

3. I/We paid work, college, or training program expenses during:

If "Yes," complete the following:

WORK, COLLEGE, OR TRAINING EXPENSES OTHER THAN TRANSPORTATION				Month 1	Month 2	Month 3
Person Claiming Expense	Type of Expense—Child Care, Etc.			Amount	Amount	Amount

  

TRANSPORTATION EXPENSES				Month 1	Month 2	Month 3
Person Claiming Expense	Method (Car, Bus, Etc.)	Daily Cost	Daily Miles	Number of Days	Number of Days	Number of Days

4. I/We had a change in real or personal property during the time scheduled.

If "Yes," complete the following, including any item received, bought, traded, sold, or given away such as land, houses, automobiles, boats, etc., and any change in your checking or savings accounts, life insurance policies, etc.

Month 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	Month 2 <input type="checkbox"/> Yes <input type="checkbox"/> No	Month 3 <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---

ITEM	WHAT HAPPENED	DATE	CURRENT VALUE	MONEY RECEIVED	MONEY OWED	OWNER

5. I/We had changes affecting the people in our family or household during the time specified:

If "Yes," complete the following, including information on someone who moved into or out of your home; entered or left a hospital; became pregnant; gave birth or otherwise ended pregnancy; entered or left school; recovered from a major illness; became disabled or died; began, changed, or terminated employment; or had a change in immigration status.

Month 1 <input type="checkbox"/> Yes <input type="checkbox"/> No	Month 2 <input type="checkbox"/> Yes <input type="checkbox"/> No	Month 3 <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	---

PERSON	WHAT HAPPENED	DATE	RELATIONSHIP	DATE OF BIRTH	INCOME	PROPERTY

6. I/We have health insurance coverage privately or through our employer. (This includes health, hospitalization [such as Kaiser, Ross-Loos, Blue Cross, etc.], or dental insurance paid by an employer, absent parent, or other person who is in or out of the home.) ☐ Yes ☐ No If "Yes," complete the following:

PERSON INSURED	INSURANCE COMPANY	GROUP/PRIVATE	PREMIUM PAID		EFFECTIVE DATE
			Amount	When	

7. Do you expect changes in any of the above, or do you have any other information affecting CMSP eligibility to report?

☐ Yes ☐ No If "Yes," please provide that information in the space provided below:

I certify that I have reported all income, property, and changes in a timely manner. California law (Welfare and Institutions Code, Section 14014) states that if you fail to report changes in income, property, or family status without good cause and such failure causes more than \$400 to be wrongly expended for medical services, you have committed a felony.

**I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.**

Signature or mark	Date signed	Complete if address has changed—street and number
Signature of spouse/parent in home	Telephone number (      )	City and ZIP code
Signature of witness, interpreter, or person completing form for beneficiary	Telephone number (      )	Complete if home address is different than mailing address— street and number